Statement of the Association of American Medical Colleges
on Increasing the Supply of Geriatricians
by
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Mr. Chairman and distinguished members of the committee, I am William L. Minnix, Jr., D. Min., President and Chief Executive Officer of the Wesley Woods Geriatric Center of Emory University. I am accompanied by Michael Whitcomb, M.D., Senior Vice President for Medical Education at the Association of American Medical Colleges (AAMC). The AAMC welcomes the opportunity to testify and participate in a discussion on how we can encourage the education and training of more geriatric physicians. The Association represents all of the nation's 125 medical schools, approximately 400 major teaching hospitals, including 75 Veterans Affairs medical centers, 88,000 faculty of these institutions represented by 86 constituent academic and professional societies, and more then 160,000 men and women in medical education as students and residents.

As educators of tomorrow's doctors and as providers of health care services, medical schools and teaching hospitals are very aware of how society's needs are changing. The nation's population is aging. Older Americans are now living healthier, better quality lives as we have become more adept at forestalling the onset of disease through scientific interventions. With increased life expectancy, the number of those age 85 and over is growing rapidly. However, there are identifiable groups of older persons who are frail and more vulnerable and require significant resources or even lack access to services. Aware of these demographic changes and concerned about the long-term financial viability of the Medicare program confronting an aging "baby boom" generation, Congress created the National Bipartisan Commission on the Future of Medicare in the Balanced Budget Act of 1997 to make recommendations on a comprehensive approach to preserve the Medicare program.

At the same time, the health care system is undergoing a number of decisive paradigm shifts that affect the provision of health care services and the way we educate and train physicians. These sweeping changes demand new educational imperatives and redesign of the way we educate and train all types of physicians, including geriatricians, and other health care givers. Health care is shifting from:

- its historic orientation toward the individual patient to concern about the health status of defined populations as well as the well-being of individuals;
- physician-centered and specialist-oriented patterns of care to integrated teams of health professionals centered on primary care;
- a preoccupation with episodes of illness to a more balanced emphasis across the spectrum from health maintenance to disease prevention to diagnosis and treatment;
- hospital-centered systems of care to broad-based, integrated systems using accessible and affordable ambulatory care, community sites and home care as well as hospitals; and
- patient management strategies that seek every available benefit, however marginal or costly to strategies that value effectiveness and parsimony in the use of clinical resources and that weigh evidence over convention in clinical decision making.

The need for practicing geriatricians and clinicians trained in the care of the elderly has been well documented by the presenters in the previous panel. We appear before you today to explain what

medical schools and teaching hospitals are doing to encourage the training of physicians who care for the elderly and to offer suggested strategies for those responsible for medical education and recommendations for Congress to improve the supply of geriatricians and other physicians who care for the elderly. Medical education is a complex and long process. There are no "quick-fix" solutions to shifting the medical education paradigm, but medical educators are taking steps to ensure that newly trained physicians are well-schooled in providing high quality health care for our senior Americans.

Before explaining how medical educators are enhancing geriatric education, it is useful to review the medical education process. Medical education takes place along a continuum, starting with four years of undergraduate medical education. In these years of medical school, students learn content, that is the knowledge, skills, values and attitudes needed for the practice of medicine and are exposed to clinical practice. They graduate as "undifferentiated" physicians. Medical school generally is followed by three to seven years of graduate medical education (GME) in a clinical setting. In their residency years, new physicians apply the content of undergraduate medical school to patients in clinical settings and specialize in their chosen discipline. As practitioners, physicians evolve their style of practice based on clinical experience and ongoing formal and informal education. Physicians are keenly aware of the need for continued learning, and participate in programs of continuing medical education (CME). The concepts of independent lifelong learning and continuous adaptation of new knowledge and techniques to medical practice define what it means to be a physician.

Opportunities to integrate learning about the care of older people abound along the entire medical education continuum and geriatricians play key roles in this teaching. Medical schools, teaching hospitals and a variety of other organizations have been devising and implementing new methods and approaches to change and improve the medical education process at the undergraduate, graduate, and continuing medical education levels.

Undergraduate Medical Education

Over fifteen years ago, the AAMC took the position that this country's changing demography demanded that all physicians should be trained to treat the elderly patient. With sponsorship from the National Institute on Aging and the Pew Memorial Trust, an advisory committee developed a report on the preparation for improved geriatric care in the undergraduate medical education curriculum. Five responsibilities of medical schools to accomplish the goal of better undergraduate preparation for the treatment of the elderly patient were outlined and schools were encouraged to:

- provide a focus for change in the educational and training programs to increase attention to the aging process and elderly patients;
- seek support to expand research in aging to improve clinical care, to stimulate medical student interest in the fields of gerontology and geriatrics, and to foster interactions with other specialties and disciplines;
- offer a variety of clinical settings and patient encounters, including ambulatory, long term institution, and home care experiences, through which students can learn special arrangements for the care, diagnosis and treatment of the elderly;
- arrange for students to interact with healthy, independent elderly persons; and develop geriatric educational material within all disciplines; and
- urge scientific disciplines and medical specialty societies to develop and disseminate geriatric education material in their fields.

At the time of the AAMC's geriatric report in 1982, only 15 U.S. medical schools had identifiable, departments, sections, divisions or units in geriatrics or gerontology. For academic year 1998-99, preliminary data show that 50 medical schools have identifiable units, including 4 separate centers or units at the departmental level. Most schools have sections or divisions of geriatrics or gerontology in the departments of internal medicine or family practice.

For 100 years, medical schools in this country have undergone national oversight and review by the practicing profession, represented by the American Medical Association, and medical educators, represented by the AAMC. As the arbiter and standard setter for. medical education, the Liaison Committee on Medical Education (LCME) conducts an annual review of all accredited medical schools, including a survey of medical education programs, to assess medical schools' compliance, in specific terms, in courses of instruction and their place in the curriculum. The annual inventory of geriatrics training, like that of other disciplines needing greater prominence in the curriculum, examines how schools are complying with standards such as the following for geriatrics and related areas:

- The faculty must introduce current advances in the basic and clinical sciences, including therapy and technology, changes in the understanding of disease, and the effect of social needs on demands for medical care;

- Clinical instruction ... must include the important aspects of acute, chronic, continuing, preventive, and rehabilitative care;

- Students must have opportunities to gain knowledge in those content areas that incorporate several disciplines in providing medical care, for example, emergency medicine and the care of the elderly and disabled; and

- All instruction should stress the need for students to be concerned with the total medical needs of their patients and the effect on their health of social and cultural circumstances.

The LCME's annual survey asks medical schools how they comply with the standards from an operational perspective. As medical schools are organized in many different ways, so is the variation in medical school curricula. However, nearly every medical school requires the teaching of geriatrics. The vast majority (92 percent) teach students about geriatrics as part of a required course. While ten percent cover the topic as a separate required course, most schools offer separate elective courses in addition to the geriatrics taught as part of a required course. Medical school graduates have indicated general satisfaction with the amount of curricular time being devoted to instruction in geriatrics. In 1997, two-thirds of medical school graduates responding to the AAMC's annual Graduation Questionnaire (GQ) stated that "appropriate" curricular time was devoted to instruction in geriatrics. While these attitudes would indicate overall satisfaction, it should be pointed out that one-third of the 1997 medical school graduates thought there was inadequate time devoted to geriatrics education.

Nearly three-quarters of graduating medical students indicated that "appropriate" curricular time was devoted to death and dying issues. The vast majority of medical schools teach students about death and dying as part of a required course. In addition, students may take additional elective courses on the subject. However, a recent report by the General Accounting Office (GAO) on suicide prevention and efforts to increase research and education in palliative care noted that instruction in palliative care topics in medical schools and residencies varied greatly. Many schools reported a need to change their curriculum in this area. The AAMC is undertaking a project designed to enhance doctor-patient communication issues and to suggest strategies that medical schools and residency programs can employ in providing communications skills during end-of-life care.

There are several points during the four years of medical school when students gain experience with caring for the elderly. In the preclinical phase of medical school, typically the first two years, basic scientists discuss issues of aging and senescence as these concepts apply to physiology and pharmacology for example. Also in the preclinical years, many schools are incorporating small group tutorial curricula emphasizing problem solving and taught around cases, often involving elderly patients. Students use these cases to learn not only history-taking and diagnosis skills, but also doctor-patient communications and case management skills. For example, more than 80 percent of medical schools provide training in identifying and treating elder abuse and neglect.

Most schools also introduce students to clinical medicine early in the preclinical phase of study. These introductions to patient programs often provide ongoing interactions with the same patients, providing opportunities for the bio-psycho-social learning that is so important in understanding issues of aging. Students are assigned patients, frequently elderly, and are expected to obtain their histories and in consultation with their supervisors, devise a treatment plan. These clerkships or community preceptorships (periods of instruction) are based primarily on experiential learning. In the teaching hospital, where roughly one-quarter to one-third of all inpatient cases are Medicare enrollees, students routinely encounter elderly patients in their clinical education. Early exposure to clinical experience in a particular specialty and encounters with faculty who serve as role models and mentors during these clinical experiences are often important factors in students' career choices.

As health care shifts from hospital inpatient-centered care to integrated managed care systems utilizing a variety of ambulatory care settings, medical educators are shifting much clinical education to diverse outpatient settings. Nearly all medical schools offer student clerkships in ambulatory care settings. The system of care for the elderly must particularly be viewed as a large system of health and social services that are likely to be delivered in a variety of settings, ranging from the tertiary teaching hospital to the home. For example, nearly all medical schools provide educational opportunities in home health care as part of a required course or other educational experiences in home health. The challenges of providing a sufficient number of sites where students can learn from appropriate faculty are formidable. It is difficult to assure uniform quality of teaching from different clinical faculty in a wide variety of settings and to assess student learning.

Graduate Medical Education

Graduate medical education (GME) is recognized and accepted as an essential phase of medical education. Its principal goals are to prepare proficient practitioners of medicine and to equip them for continued professional development. Each specialty has a formally organized board that establishes the minimum length of time to be spent in training and the other criteria a resident must fulfill to be eligible for certification. While undergraduate medical education is university based and molded by the academic traditions of higher education, GME has historically been hospital-based and developed from a tradition of "on-the-job" experiential training. Many of the same concerns about providing appropriate teachers and non hospital teaching sites also are prevalent among educators of residents.

GME training programs are accredited by the Accreditation Council for Graduate Medical Education (ACGME). In practice, programs are required to submit information about their curricula to the appropriate Residency Review Committee (RRC) which evaluates the data during the accreditation process. For example, program requirements for residency education in internal medicine have a geriatric component:

Resident experience must include formal teaching and regular, supervised clinical activities in geriatric

medicine. Assignments to geriatric services must be offered, and are defined as specifically designated geriatric inpatient units, geriatric consultation services, nursing homes, geriatric ambulatory care clinics, and/or home care. (Graduate Medical Education Directory 1997-98).

Geriatrics as a defined specialty is relatively new. It was recognized by the American Board of Medical Specialties (ABMS) in 1985 as a subspecialty of internal medicine and family practice. The first examination for which a physician could become a board-certified geriatrician was offered in 1988. Thus, the specialty has not had a very long time to mature and is still developing. Residency training opportunities in internal medicine and family practice geriatrics have increased dramatically since 1989. In 1989-90, there were 50 training programs in internal medicine and family practice geriatrics approved by the Accreditation Council on Graduate Medical Education (ACGME). In 1997-98, there were 103 approved training programs.

Obstacles and Constraints to the Development of Academic Geriatrics

Increasing the visibility of geriatrics in medical schools is difficult given the current shortage of academic geriatric faculty. Faculty can serve as important role models for medical students and they can influence students' career choice. Data from the AAMC's faculty roster database show that there are only 558 faculty reporting geriatrics (either internal medicine or family practice geriatrics) as a medical specialty among the 125 allopathic medical schools. This compares with 121 faculty in June 1991 and 468 faculty in June 1995. While the number of geriatric faculty has increased more than four times since 1991, most geriatric leaders believe current numbers are inadequate.

A broad spectrum of clinical training sites where the elderly are served, from nursing homes and day care centers to physicians' offices and home care, are needed to expose medical students to elderly people with varying health status. Simply seeing elderly patients in the hospital during geriatric assessment rounds does not provide the full learning experience necessary for career choice. Patients must be evaluated in social and various care settings. However, most medical educators lament the paucity of appropriate clinical training sites at both the graduate and undergraduate education levels. Finding training sites of uniform quality and faculty who are willing to teach in these sites, particularly practitioners who must generate clinical income in a cost-conscious environment, is challenging. Establishing and maintaining high-quality educational sites is costly.

Increasing emphasis on multi-disciplinary and integrative teaching is well-suited to enhanced geriatrics education and educators are developing innovative programs. However, this demands the time and attention of a limited number of trained educators who face the demands of many competing responsibilities. Medicine is an increasingly complex field, and many worthy courses compete for students' time. Like other integrative subjects that require multi-disciplinary approaches, geriatrics needs to be well-integrated into the curriculum.

Recruitment of students into geriatrics is difficult. While the number of residency training programs in internal medicine and family practice geriatrics has increased substantially since 1989, many geriatric training positions are not being filled. In 1996, the latest year for which data are available, only 144 of 222 geriatric training positions offered were filled.

Clearly, geriatrics has not yet enjoyed a high degree of popularity with students and residents. This patient population requires particular tact and understanding. For example, patients with impaired mental capacity may not recognize their own physician. The key to more geriatricians is making the specialty more attractive to students as a career choice. The AAMC has invested significant effort to learn as much as possible about medical student specialty choice by asking graduating seniors about

factors influencing specialty choice. The results-and they haven't changed materially from year-to-year-tell us that medical students are influenced by their educational experiences. These include positive clerkship experiences and physician role models. Students also pick specialties that interest and challenge them intellectually and that are consistent with their altruistic values and personalities. With more role models and the opportunity to see the elderly in ambulatory settings, students should develop increased interest in this career.

A significant constraint in attracting more medical students to train in geriatrics is the comparatively low level of payment for primary care and evaluation and management services under the Medicare Fee Schedule and other third party payment systems. The vast majority of geriatricians' services provided to Medicare beneficiaries are visits and consultations. While certain provisions in the Balanced Budget Act of 1997, in particular the transition to a single dollar conversion factor and the implementation of a resource-based practice expense system, will boost payments to primary care physicians the aggregate gains in payment have not been as high as originally anticipated when the Medicare physician fee schedule system was proposed.

Exacerbating the problem of comparatively low compensation levels is that academic physicians, including academic geriatricians, must devote a large percentage of their time-up to 50 to 60 percent-to teaching and research activities. Time spent in these activities reduces the time available for providing billable patient care services that contribute to the department's total operating revenue. In addition to paying general departmental expenses, a significant portion of this revenue derived from patient care services helps maintain competitive compensation levels of the clinical faculty and supports the general medical education and research programs of the medical school.

AAMC Activity Related to improvements in Medical Education

The AAMC and its members are fully aware and sensitive to the perception that the graduates of our current medical education system may be misaligned with what society wants and needs from the medical education community. Society now recognizes the need for a broader view of health care and wants doctors who can and will attend equally well to all aspects of health care.

As part of a major initiative to address societal concerns the AAMC embarked on a project to assist medical schools in their efforts to create a better alignment between the training of new doctors and society's expectations of physicians. Called the Medical School Objective Project (MSOP), this effort is not directed specifically at geriatrics education, but applies to all medical education. In recognizing new expectations, the MSOP panel reached consensus on a set of four overarching attributes that characterize the qualities all physicians must possess: they must be altruistic, knowledgeable, skillful and dutiful. The panel also set forth learning objectives for the medical student curriculum derived from those attributes. The attributes and objectives apply equally to the education of geriatricians as they would any other medical career choice.

In January 1998, the AAMC issued the first report which sets forth the objectives that can guide medical schools in developing goals that reflect an understanding of the implications for medical practice and medical education of evolving societal needs, practice patterns, and scientific developments. Among them is that medical school graduates must demonstrate an understanding of, and respect for, the roles of other health care professionals, and the need to collaborate with others in caring for individual patients and in promoting the health of defined populations. Physicians must feel obliged to collaborate with other health professionals and to use systematic approaches for promoting, maintaining and improving the health of individuals and populations.

Emphasis on interdisciplinary learning as the health system shifts from physician-oriented systems of care to systems utilizing teams of health care professionals is critical, particularly in geriatrics. Interdisciplinary teams, in which health professionals from multiple disciplines apply their special skills, knowledge and values to achieve common goals, can enhance innovation, improve the quality of patient care, and strengthen academic-clinical ties and partnerships among institutions and settings. While the challenges of changing behavior and cultures are great, the benefits from interdisciplinary education have huge potential.

The MSOP report also notes that in caring for individual patients, physicians must apply the principles of evidence-based medicine and cost effectiveness in making decisions about the utilization of limited medical resources. They must be committed to working collaboratively with other physicians; other health care professionals, and individuals representing a wide variety of community agencies. As members of a team addressing individual or population-based health care issues, they must be willing both to provide leadership when appropriate and defer to the leadership of others -when indicated. They must acknowledge and respect the roles of other health professionals in providing needed services to individual patients, populations or communities.

As part of the MSOP project, the AAMC convened a panel to provide guidance on educational objectives related to population health, and how medical schools might design and implement educational strategies to achieve the MSOP panel's recommended objectives. A draft report outlines the educational objectives for imbuing a population health perspective in medical students and makes recommendations for change, including examples of suggested educational activities. One barrier to change has been that population health instruction is cross-disciplinary, with no one department having responsibility for the competencies. As a result, medical schools, serving as the accountable organizational entity, must clearly delineate the expected outcomes of training in population health so that they can be met explicitly. Additionally, the report calls for faculty development by identifying positive teachers and mentors who are well-versed in the elements of managed care.

The report has been endorsed by the American Association of Health Plans (AAHP). The AAHP appointed a team of medical educators to review the report. The reviewers made some editorial clarifications to the document. After the team's review, the document was approved as submitted by the AAHP's Quality Committee and then by the governing body of the AAHP.

Already medical schools are using the MSOP guidelines to evaluate and, if necessary modify, their curricula. Twenty-four schools have formed a consortium that will play an active role in implementing the next phases of the project.

Suggested Strategies for Schools of Medicine

In addition to revising constantly physician education due to advancements in scientific and medical knowledge and changes in treatment patterns, medical schools may wish to adopt several strategies to attract medical students to geriatrics. In 1992, the AAMC issued a report on the generalist physician that recommended an action agenda to increase the attractiveness of primary care medical careers. Many of these strategies, repeated from the report on the generalist physician in boldface type below, have been successfully employed to increase the number of students choosing careers in primary care specialties. They also can be utilized to increase the number of students choosing careers in generalist specialties from which geriatricians tend to obtain their residency training.

Schools of medicine should establish administrative units for the generalist specialties. Medical schools should establish administrative units for geriatrics where the responsibility for leadership and

management of its educational effort can be focused to assure adequate support. Such units need not be formal departments or even divisions within departments, but should have sufficient administrative authority to be effective champions for the care of the elderly. Having a separate department does not necessarily mean that students will be exposed to geriatric patients. A variety of educational experiences in diverse settings such as nursing homes, home care and other nonhospital settings will expose the student to the broad spectrum of the elderly population. Every doctor in primary care and specialty medicine should be fully knowledgeable about the many diseases and disabilities of old age, and understand the techniques of maintaining function in older patients.

To recruit and advance faculty, medical schools should provide appropriate academic recognition for scholarship, teaching and role modeling among faculty in the generalist specialties. The contributions and special skills of geriatric faculty should be recognized and rewarded. Faculty from geriatrics should serve on key administrative and planning committees in the institution. The current traditional system of rewards may limit the prestige of geriatrics as a discipline, impairing the school's ability to attract and sustain adequate faculty. Retraining of existing mid-level faculty also should be considered.

Medical schools should foster research opportunities in the generalist fields among faculty, residents and students. With the explosion in scientific discovery, there are many unanswered, urgent questions about aging. Geriatrics is poised to play an important role in meaningful research efforts to help better understand aging and disability.

Medical schools should require that all medical students have meaningful curricular experiences in the generalist specialties. This includes clinical experiences in nonhospital settings and the opportunity to encounter role models among the faculty who teach geriatrics. Most medical students make their specialty choice before the end of the third year of medical school. The early introduction of positive experiences in clerkships, preceptorships or other educational activities related to the elderly population in nursing home or home care settings, for example, will ensure that students have an appropriate base for making career decisions. Effective role models are likely to raise student interest in geriatrics.

It also is important for medical schools to partner with a variety of public and private entities. Medical schools and teaching hospitals should seek relationships that enable them to develop teaching chronic care systems for senior care. For example, a rural hospital may want to develop a senior care system, partnering for referrals of the sickest patients and sending physicians to the academic center for "in-career" internships during which the physician works alongside academic geriatricians for a limited period of time. Private money may need to be raised to support such efforts. Institutions could also develop systems that break down bureaucratic barriers to care coordination. Medicare, Medicaid and Title In are not well-integrated and pulling together agencies that deal with these programs could be beneficial.

Recommendations for Congress

The AAMC also recognizes that the federal government can support an increase in the number of geriatricians trained through a variety of mechanisms:

Provide adequate support for existing federally-sponsored student loan re-payment programs. Students who show interest in geriatrics may hesitate to choose the specialty due to high levels of educational debt because they cannot afford to study geriatrics for two additional years. The AAMC believes that if monetary incentives are provided, they should be directed at individuals. A variety of

federally-sponsored student loan programs, such as the National Health Service Corps program, already exist.

Provide adequate funding support for Tide VII geriatrics programs. Increased funding is needed to support multi-disciplinary geriatric education centers (GECs) and geriatric training programs (GTPs). Both types of programs are effective in providing opportunities for health care personnel to develop skills for providing better, more cost effective care for older Americans.

Affiliated with educational institutions, hospitals, nursing homes, community-based centers for the aged, and veterans' hospitals, GECs include short-term faculty training, curriculum, and other educational resource development, and technical assistance and outreach. GTPs provide fellowships for medical and dental faculty and provide for curriculum development, the hiring of faculty, and the first three months of fellowship training.

Establish a new career development program for academic geriatricians. The Health Professions Education Partnership Act of 1998 (S. 1754) would require the Secretary to establish a program to provide Geriatric Academic Career Awards to junior faculty to promote careers in academic geriatrics. The amount of a five-year award would be $50,000 in FY 1998 and would be adjusted for inflation in subsequent years. Individuals who received awards would be required to provide training in clinical geriatrics, including the training of interdisciplinary teams of health care professionals. Such a program would provide critical faculty support as faculty are under pressure to generate clinical revenue in an increasingly price-sensitive health care system.

Provide adequate support for the Geriatric Research, Education and Clinical Center (GRECC) program in the Department of Veterans Affairs. Established in 1975, the GRECC program increases the basic knowledge of the aging process, shares the knowledge with other health care providers, and improves the overall quality of health care received by elderly veterans. The 16 GRECCs established by the VA are at the forefront of the fields of gerontology and geriatrics. A 1997 audit by the Inspector General (IG) of the VA noted that "the GRECC's integration of research, education, and clinical care activities at major research facilities was an effective method for addressing the health needs of the elderly." The IG recommended the development of a method for implementing GRECC-developed treatment models and educational programs at more VA facilities. It should be noted that the VA maintains many programs for older veterans, including 121 geriatric evaluation management (GEM) programs across its system. Aimed at keeping the frail elderly out of nursing homes, these GEMs provide comprehensive health care assessments and other services to veterans with multiple medical problems and those with geriatric problems.

Consider allowing the Secretary of Health and Human Services to engage in a thoughtful process for determining whether the Medicare program should pay for residents in shortage specialties beyond the hospital-specific resident limits. The Balanced Budget Act of 1997 placed an overall limit on the number of full-time equivalent residents for which the Medicare program would make direct GME and indirect medical education (IME) payments to each hospital. The Congress may wish to allow the Secretary to consider establishment of an exceptions process for the training of types of physicians in short supply.

The Medicare Physician Fee Schedule should pay for physician case management services, CPT codes 99361 - 99373, and preventive medicine services, CPT code 99387. Physician case management as well as preventive medicine services are currently not listed for separate payment among the covered services in the 1998 Medicare Fee Schedule system. Instead, these activities are "bundled" into other services. As a result, a significant amount of physician work extended to coordinate and to assure that the Medicare beneficiary is provided continuity of care across delivery settings by a multi-

disciplinary team of care providers, is not a separate billable service. Further, periodic patient evaluations to identify potential risk factors and to discover the onset of a disease in its early stages also are not separately billed to Medicare, although they are now typically covered by managed care plans and other third party payers that have recognized the significant cost and quality benefits of preventive medicine services.

While primary care physicians may see a significantly higher percentage of complex patients that merit billing a visit or consultation service at a level 4 or 5, government and institutional concerns over fraud and abuse are so intimidating that many physicians are reluctant to code at the higher level for fear of their inability to document adequately to substantiate the higher charge. This fear must be assuaged by the Health Care Financing Administration in the future.

Conclusion

As revolutions continue in biomedical science and health care services, revolutionary forces also are being exerted on medical education. Medical educators are transforming our educational paradigm by adopting a broader focus incorporating responsibility for the life-long learning that physicians will need to maintain relevant knowledge and skills in a rapidly changing profession. The AAMC recognizes that increasing the number of geriatric physicians calls for action on at least two fronts: voluntary efforts by private sector organizations and government action to eliminate barriers that prevent us from meeting the need. Medical schools, teaching hospitals and other private organizations should work with governmental bodies to find and craft solutions for increasing the number of geriatricians.